STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 37 6/19/06 [12:55 pm], "pt [patient] continues on ABT for UTI [urinary tract infection]..." 6/24/06 [9:45 am], "pt cont[inues] on ABT/UTI...pt is chronic/UTI.." 7/5/06 [8:00 pm], "Complaining of increase incontinence urinary. Stated she has started dribbling urine when she stands up. Does not have any voiding sensation would just feel underpants wet..." 7/12/06 [un-timed], "Resident complaining of urinary frequency when resident stands urine just poors [sic] out. phoned [physician's name] for urology recommendation." On 7/10/06 at 10:45 am, two CNAs were observed assisting the resident out of bed. The resident was observed to be provided total incontinence care by two CNAs. The CNAs changed the resident's incontinence briefs and provided peri-care. On 7/11/06 at 6:15 am, the resident was observed in bed, on her back, asleep. The resident was observed in this same position at 6:55 am. From 6:55 am until 9:50 am, the resident's room was continuously observed. During this time frame, no direct care staff were observed to enter the resident's room to offer toileting or provide incontinence care to the resident. On 7/11/06 at 10:00 am, a CNA was interviewed regarding the resident's morning routine. The CNA stated the resident did not like to get up before 10:30 am.	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 38 On 7/12/06 at 8:45 am, the DON was interviewed. The DON was informed of the surveyor's observations of the lack of toileting for resident #4 and the lack of a bladder assessment following the removal of her Foley catheter on 3/24/06. The DON stated that she would look into it. On 7/12/06 at 1:00 pm, the DON and a LN, familiar with resident #4, were interviewed again. The DON acknowledged no bladder assessment could be located after the removal of the catheter until 7/4/06. She also acknowledged the decline in the resident's bladder functioning from being continent before her hospitalization and now being frequently incontinent. It was also stated the resident had a lot of issues with her bladder and that she did not feel the urge or need to go. It was also acknowledged the resident did not want to get up in the morning and would refuse cares when offered. The facility failed to maintain resident #4's continent bladder function. The facility failed to assess resident #4's bladder function following the removal of an indwelling catheter. A complete bladder assessment was not done until over 3 months after the removal of the catheter. This resident who was assessed as being continent prior to the placement of the catheter and was now assessed as being frequently incontinent and had recurrent urinary tract infections.	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318 SS=E	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interview, it was determined the facility did not ensure residents received range of motion through the restorative nursing program, on a consistent basis, as they were care planned to receive. This affected 7 of 13 sampled residents (#6, 7, 8, 10, 11, 12 and 13). Findings include: 1. Resident #10 was admitted 10/4/04 with diagnoses that included gastritis, hypertension and depression. The annual MDS assessment dated 6/20/06, indicated the resident had normal cognition and decision making abilities, had unsteady balance when standing, used walker and wheeled self in wheelchair, fell in the past 30 days, and training and skill practice in walking indicated a zero. On 7/10/06 at 10:00 am, resident #10 indicated she wished she could be assisted to walk at least daily. She said she had fallen twice since admission. She said she usually took herself to the bathroom but often felt unsteady when doing it. The care plan with an update of 5/24/06 and RNA Flow Sheet for the month of July 2006 indicated the resident was to "ambulate 75-100 feet with standby assist and FWW [front wheel	F 318	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F 318 IDENTIFIED RESIDENTS: Resident #6, 7, 8, 10, 11, 12. 13: Restorative aide schedule has been adjusted to meet the needs of all residents who are on the restorative program. Resident # 8 has been assessed by therapy services and interventions put in place to address tightness in hand and hips. Has been placed on restorative caseload. This citation has the potential to impact all residents in the facility who are currently care planned for Restorative Nursing. The following measures have been taken to assure ongoing compliance: • Restorative Nurse Aide schedule has been adjusted. Restorative Aide will maintain consistent schedule to assure residents receive restorative as indicated in their plan of care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 40 walker] daily, Cue to stand from sitting for 10 Reps daily, Theraband exercises for shoulder flexion extension 4-6 X week, Theraband exercises for hip flexion 4-6 X week and Theraband exercises for hip abduction/adduction 4-6 X week." Documentation on the RNA flow sheet did not indicate the services had been provided between 7/1 and 7/12/6. The DON indicated on 7/12/06 at 9:00 am, "Our restorative nursing program is being reorganized. It is possible that some treatments have not been done." 2. Resident #8 was admitted 3/22/06 with diagnoses that included Alzheimer's disease, dementia, depression, hypertension and osteoarthritis. The quarterly MDS, dated 6/18/06, documented the resident had no ROM limitations. The care plan, with an update of 5/4/06, directed under Physical Mobility the resident had impairment related to rigidity of upper and lower extremities. Under approach, the care plan directed, "refer to restorative program as needed." During observations of the resident while in bed, on 7/10/06, at 10:00, 10:10, 10:20, 10:45, 11:00 am, 2:00 pm and on 7/11/06 at 6:30 am, the resident was observed dependent for all care and inactive. She was observed with her right hand positioned into a tight fist. Her legs were continually crossed. On 7/10/06, while providing care at 11:00 am, an aide indicated the resident always crossed one leg over the other making it difficult to do peri care. The aide also validated	F 318	• Staffing Coordinator has been educated regarding Restorative Nurse Aide expectations for scheduling purposes • Nurse Manager responsible for Restorative oversight will meet with Restorative Aide at least monthly to review case load and documentation MONITORING AND ONGOING COMPLIANCE: • The Director of Nurses and Nurse Managers will monitor for compliance through review of documentation of Restorative cares provided. Identified areas of concern will be resolved immediately and addressed as needed in the facility Performance Improvement meeting. Completion date: August 15, 2006	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 41 the resident maintained a continuous fist position with her right hand. Documentation did not address awareness of these rigid positioning problems and consideration of the need for ROM. On 7/11/06 at 1:00 am, the LN indicated resident #8 received ROM during regular cares. 3. Resident #11 was admitted on 7/3/02 with diagnoses that included dementia with behaviors, hypertension, hypothyroidism and depressive disorder. During an observation of care on 7/12/06 at 9:30 am, staff indicated while providing care that the resident was inactive and usually very stiff. Documentation did not indicate that ROM assessment had been initiated addressing all joints. The care plan indicated the resident was to receive passive ROM and gentle massage to the right wrist/hand for 10 repetitions daily. During the month of June, 2006, restorative documentation indicated the resident did not receive ROM on 24 of the 30 days. From July 1 to July 12, 2006 restorative documentation indicated the resident did not receive ROM exercises on 10 of the 12 days. 4. Resident #12 was admitted to the facility on 6/10/03 with diagnoses of hemiplegia and pleural neuropathy. To address her impaired mobility, the 5/22/06	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 42 Care Plan included the following: "Assisted ROM (range of motion) to upper extremities 10 reps (repetitions) each area daily. Document # (number) of reps, tolerance (+/-), initials." "Passive ROM to lower extremities, 10 reps for each area daily. Document # of reps, tolerance (+/-), initials." Resident #12's medical records and flow sheets did not contain documentation of the ROM exercises. On 7/13/06 at 8:35 a.m. the Restorative aide was interviewed and stated she had not been regularly assigned to restorative duties. She stated residents received passive ROM as they were dressed in the morning, but no documentation of the assisted ROM as described in the Care Plan was occurring. The Physical Therapist was interviewed on 7/13/06 at 9:45 a.m. and confirmed resident #12 did not currently received services from the therapy department. 5. Resident #6 was admitted to the facility on 7/29/99 with diagnoses of subdural hematoma, coma, quadriplegia and depression. Resident #6's quarterly review assessment MDS dated 4/16/06, documented the resident's cognition pattern as comatose, range of motion for neck, arm, hand, leg and foot as limited on both sides and voluntary movement for neck, arm, hand, leg and foot as full loss. The MDS documented under "Nursing Rehabilitation/Restorative Care", "Range of motion (passive) 6." The resident's care plan dated 2/9/06, identified	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 43	F 318		

the problem, "Mobility issues...increased lateral neck flexion with varying degrees in measurement..." The following approach was listed: "...Slow gentle stretch/PROM [passive range of motion] to right and left shoulders X [times] 10 reps [repetitions], hold for 10 counts daily..."

The resident's 6/06 and 7/06 "Flow Sheet Records" documented, "Slow gentle stretch/PROM to right and left shoulders X [times] 10 reps, Hold for 10 counts daily." The flow sheets documented the resident received passive range of motion to the shoulders on 6/12, 6/13, 6/14, 6/15, 6/17, 6/26 and 6/27/06. The remaining days of June and July were left blank, indicating the resident did not receive passive range of motion on those days.

6. Resident #7 was admitted to the facility on 12/3/04 and readmitted on 2/8/05 with diagnoses of cerebrovascular accident with hemiparesis, insulin dependent diabetes mellitus and hypertension.

Resident #7's quarterly review assessment MDS dated 4/18/06, documented the resident's range of motion for arm, hand and leg as limited on one side and voluntary movement for arm, hand and leg as partial loss. The MDS documented under "Nursing Rehabilitation/Restorative Care", "Range of motion (Active) 2."

The resident's care plan dated 5/22/06, identified the problem, "Physical mobility, impaired R/T fall(s) R/T weakness R/T unsteady gait R/T old CVA with left sided weakness R/T unable to do car transfers R/T decreased bed mobility." The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 44 following approaches were listed: "...(15) Include in restorative ROM [range of motion] program. Supine ankle pumps X 10 reps 4-6X/week with yellow - red theraband...(16)...Supine short ARC quads X 10 reps 4-6X/week with yellow - red theraband...(18)...Supine straight leg raises X 10 reps 4-6X/week with yellow - red theraband... (19)...Hip abduction/adduction with red theraband X 2 sets of 10 reps 4-6X/week...(30)...Knee flexion with red theraband X 2 sets of 10 reps 4-6X/week...(31)...Hip extension with red theraband X 2 sets of 10 reps 4-6X/week... (32)...Sit to stand X 2 sets of 10 reps 4-6X/week..." The resident's 6/06 and 7/06 "Flow Sheet Records" documented, "Include in restorative ROM program. Supine ankle pumps X 10 reps 4-6X/week with yellow - red theraband...Supine short ARC quads X 10 reps 4-6X/week with yellow - red theraband...Supine straight leg raises X 10 reps 4-6X/week with yellow - red theraband...Hip abduction/adduction with red theraband X 2 sets of 10 reps 4-6X/week..." The flow sheets documented the resident received active range of motion on 6/14. The remaining days of June and July were left blank, indicating the resident did not receive active range of motion on those days. 7. Resident #13 was admitted to the facility on 2/21/02 with diagnoses of CVA (cerebrovascular accident), HTN (hypertension), depressive disorder, and Alzheimer disease. The annual MDS assessment dated 3/16/06, documented the resident's range of motion was limited on 1 side to the arm and hand. The resident's quarterly MDS dated 6/11/06,	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 45 documented the resident's cognition was moderately impaired and needed extensive assistance with dressing and personal hygiene. The care plan dated 6/15/06, problem #8, dated 2/21/02, documented, "Physical mobility impaired." Approach #22, dated 9/08/03, documented," the resident was to receive passive range of motion to the right hand, close fingers into a fist, then open and hold fingers straight for 10 repetitions every day, and then document numbers of repetitions and tolerance of activity." Approach #24, dated 3/01/04, documented, "resident was to receive range of motion to the knees for 5 repetitions daily before walking, then document numbers of repetitions and tolerance of activity." Approach #25, dated 3/01/04, documented, "resident was to receive range of motion to hips for 5 repetitions before walking daily. Then, document numbers of repetitions and tolerance for activity." The "Flow Sheet Record" for 6/1/2006 thru 6/30/2006, documented the range of motion to knees and to hips was not completed for the month of June. The passive range of motion to the right hand was documented as completed on 6/12, 6/13, 6/14, 6/15, 6/17, and 6/26. No documentation was recorded that range of motion excercises were provided from 6/1 through 6/12, on 6/16, 6/18 through 6/26, and on 6/27 through 6/30.	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility did not ensure that each resident received adequate supervision and assistance devices to prevent injury to feet by using incorrect mechanical lifting, by using arm protectors as needed and by using a mat on the floor next to the resident's bed to protect the resident from falling on a hard surface. This deficient practice affected 3 of 13 sampled residents (residents #3, #8, and #12). The findings include: 1. Resident #3 was admitted to the facility on 12/02/03 with diagnoses of open reduction internal fixation of the right hip, pressure ulcer, MS (multiple sclerosis) with quadriparesis, and CVA (cerebrovascular accident). The resident's quarterly MDS dated 4/19/06 documented the resident's cognition was moderately impaired and the resident was totally dependent for her ADLs, such as ambulating, dressing, and personal hygiene. Resident #3 was also a 2 person total assist with a Hoyer mechanical lift. The care plan dated 5/24/06, problem #01, approach #07, documented, "Transfer with 2 person assist using mechanical lift." An investigation on the "Resident Event Report,"	F 324	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F 324 IDENTIFIED RESIDENTS: #3: Resident has been moved to a room which will better accommodate the use of mechanical lift. Staff have been educated regarding notifying Nurse Manager of concerns regarding safety with transfers. #12: Geri sleeves applied when concern identified. Cardex updated to reflect the need to utilize long sleeves or geri sleeves at all times. Resident has been changed to a mechanical lift to reduce potential of skin related issues, due to her extremely fragile skin. #8: Mats placed on bilateral sides of the bed when concern identified. This citation has the potential to impact all residents in the facility identified to be at risk for injury related to incidents. The following measures have been taken to assure ongoing compliance: • Staff educated regarding following plan of care for resident safety issues	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 324	Continued From page 47 dated 7/8/06, stated the following,"Left tarsal area: . . . Area is dark in color, irregular in shape, with a hard center. This was a resolved skin area that has significant scar tissue. Wound nurse states this dark area is related to bumping the side of her foot while transferring her via mechanical lift into bed, resulting in trauma to a healed area with scar tissue. She came to this determination after observing the actual hoyer transfer of [resident #3] on 7/3. States she did provide education to the aides at that time, assuring they were aware of how to transfer resident. . . " On 7/10/06 at 1:50 pm, the resident was transferred with 1 CNA to bed from the wheelchair with a Hoyer mechanical lift. There was no injury at this time, however, due to improper technique there was a potential for injury. The resident was observed on 7/11/06 at 11:40 am, being lifted with a Hoyer mechanical lift from the resident's bed to a chair. As the two CNA's moved the resident to the chair, the resident's left lateral aspect of the foot hit a nearby table. This was the location of the sore with a wound dressing. The resident was asked if there was any pain and stated, "I have no real feeling in my feet anyway, so it did not hurt." On 7/12/06 at 1:00 pm the DNS stated that she had done inservices in the past with CNAs to prevent injuries, but that she would do more inservicing with CNAs right away. The facility did not ensure that the resident had adequate supervision and assistance to prevent	F 324	• Nurse Managers educated regarding ongoing auditing to assure safety measures are consistently in place MONITORING AND QUALITY ASSURANCE • The Director of Nurses and Nurse Managers will monitor for ongoing compliance through random audits and observations. Identified areas of concern will be immediately resolved and addressed as needed in the facility Performance Improvement meeting. Completion date: August 15, 2006	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 324	Continued From page 48	F 324		

improper transfers and to prevent the potential for accidents.
2. Resident #12 was observed in the dining room during the tour on 7/10/06 at 9:00 am. Her arms were thin and bare. The right arm below the elbow had a healing skin tear with tape still attached to the wound. Surrounding the area of the skin tear was a 3 to 4 inch area of peeling and very dry looking skin. On 7/11/06, the resident was observed with bare arms at 8:30 am and at noon. On 7/12/06 at noon, the resident was wearing arm protection on the right arm only.

The care plan, dated 5/22/06, included, " 6/30/04 - Skin integrity impaired...Geri gloves or long sleeved blouse on to promote optimal skin integrity." According to her 6/4/06 Care Plan update, she had sustained a skin tear to her right upper arm, and directed use of arm protectors at all times. Not consistently using arm protection could have potentially resulted in the skin tear.

3. Resident #8 was admitted 3/22/06 with diagnoses that included Alzheimer's disease, dementia, depression, hypertension and osteoarthritis.

An incident report, dated 4/14/06, documented, "resident rolled onto floor with bed in low position - mat was on the other side." Under recommendations it directed, "mats on both sides of bed on floor."

The care plan, with an initial start date of 3/31/06, directed, "lo bed...and mats on floor."

On 7/12/06 at 1:30 pm, the LN indicated the use of the mat had been changed and it was now to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 324	Continued From page 49 be placed on the floor on the side the resident was laying toward. During hourly observations of the resident while in bed, on 7/10/06 at 10:00, 10:10, 10:20, 10:45, 11:00 am, 2:00 pm and on 7/11/06 at 6:30 am, a mat was always placed on right side of the bed on the floor, no matter what side the resident was turned toward. On 7/12/06, at 2:00 pm, the resident was observed in bed, turned on her left side. The mat was on the floor on her right side. A clear plan for prevention of injury had not been implemented.	F 324	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 328 SS=E	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility did not ensure that residents received proper treatment and care related to respiratory care and podiatry care. This deficient practice affected 5 of 13 sampled residents (#'s 2,	F 328	F 328 IDENTIFIED RESIDENTS: #2, 3, 8: Podiatrist in and provided services to residents #4, 13: Oxygen adjusted when concern brought to nursing's attention This citation has the potential to impact all residents needing special services. The following measures have been taken to assure ongoing compliance: • Podiatrist contacted, and has been in to see all residents needing podiatry service • Nurse Managers educated to set appointment for visiting Podiatrist, or to see outside Podiatrist when concern identified • If in-house Podiatrist, Nurse Managers will set up appointment with outside Podiatrist	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 50 3, 4, 8 and 13). The findings include: 1. Resident #3 was admitted to the facility on 12/02/03 with diagnoses of open reduction internal fixation of the right hip, pressure ulcer, MS (multiple sclerosis) with quadriparesis, CVA (cerebrovascular accident), and COPD (chronic obstructive pulmonary disease). The quarterly MDS, dated 4/19/06, documented the resident's cognition was moderately impaired in her daily decision making. On 7/10/06 at 1:15 pm, resident #3's toenails were observed to be long and thick. In an interview on 7/12/06 at 8:45 am, with the DNS, surveyor discussed the issue of the the toenails on resident #3. The DNS indicated she would check the Podiatrist visit list and get us that list. On 7/13/06 at 12:25 am, resident #3 was assessed by the nurse practitioner and the DNS in the presence of the surveyor. At that time, the resident's feet were observed. During this assessment, the nurse practitioner stated, "the resident needs to be seen by the podiatrist." The DNS also acknowledged the problem and indicated she believed the resident was on the Podiatrist visit list and would get the surveyor a copy of that list. No further information was received. 2. Resident #4 was originally admitted to the facility on 8/30/03 and readmitted on 3/17/06 with diagnoses which included acute gastrointestinal bleed, COPD (chronic obstructive pulmonary	F 328	MONITORING AND QUALITY ASSURANCE • Director of Nurses will monitor through random audits and observations. Identified areas of concern will be resolved immediately and addressed in the facility Performance Improvement meeting as needed. Completion date: August 15, 2006	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 51	F 328		

disease), CAD (coronary artery disease), polymyalgia, and schizoaffective Disorder.

Review of the quarterly MDS, dated 7/04/06, indicated the resident's cognition was moderately impaired.

Review of the "Physician's Orders Recapitulation," dated 6/01/06, and signed by the Physician on 5/31/06, revealed an order for oxygen, "O2 (oxygen) at 2L (liters) via NC (nasal canula) continuous, for COPD."

Observations on 7/10/06 at 10:45 am and 2:35 pm; on 7/11/06 at 7:30 am; and on 7/12/06 at 11:20 am, revealed the resident was sleeping with her oxygen on. The oxygen was set at 3L on the bedside oxygen concentrator.

On 7/12/06 at 1:00 pm, the DNS was interviewed. It was discussed with the DNS that the oxygen levels on resident #3 had been set at 3L on 7/10/06, 7/11/06, and 7/12/06. The DNS stated, "I will check this and talk to staff." No further information was received.

3. Resident #13 was admitted to the facility on 2/21/02 with diagnoses of CVA (cerebrovascular accident), HTN (hypertension), depressive disorder, and Alzheimer disease.

The quarterly MDS, dated 6/11/06, revealed that the resident's cognition was moderately impaired, and decision making was poor.

The "Physician's Orders Recapitulation," dated 2/25/05, revealed an order for, "oxygen at 3 liters/minute via NC (nasal canula) continuous."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 52 Observations on 7/12/06 at 11:30 am, revealed that while resident was in the dining room in his wheelchair and waiting for lunch, the portable oxygen tank was set at 1.5 L (liters). On 7/13/06 at 7:50 am, while resident was in the dining room waiting for breakfast, the portable oxygen tank was set at 2 L. 4. Resident #8 was admitted 3/22/06 with diagnoses that included Alzheimer's disease, dementia, depression, hypertension and osteoarthritis. The quarterly MDS assessment, dated 6/18/06, indicated the resident's cognition was severely impaired and she was dependent for all cares. The resident's toenails were observed on 7/10/06 at 11:30 am. They were thick, long and rough. On 7/10/06 at 1:00 pm, a LN indicated that because of the thickness of the nails, the resident should be seen by the Podiatrist. 5. Resident #2 was admitted on 5/28/04. His diagnoses included left lower leg amputation, multiple sclerosis, depression, neurogenic bladder and right fractured neck of the femur. The annual MDS assessment, dated 5/20/06, indicated the resident had normal cognition and was dependent for all cares except with eating. The resident's toenails on his right foot were observed on 7/10/06 at 2:00 pm with the wound care LN. The resident's toenails were rough, long and jagged. The tips of his toes were inflamed.	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 53 The skin on his foot was dry and flaky. The resident indicated he did not want anyone to trim his toenails except the Podiatrist. The resident also said it had been a while since the Podiatrist had visited. On 7/11/06 at 2:30 pm, the resident's toes and foot were again observed with the LN in charge of the resident. She indicated the nails were long, jagged and had sharp areas. On 7/11/06 at 1:30 pm, the wound nurse indicated the last time the Podiatrist saw the resident's feet was on 2/9/06 and since February no referral had been sent to schedule an appointment with the Podiatrist for resident #2. This is a repeat deficiency from the 6/10/05 recertification survey.	F 328	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F 329	
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure that residents receiving medications for behaviors were adequately assessed, reviewed, monitored and a gradual dose reduction	F 329	IDENTIFIED RESIDENT: #11: Resident's Depakote has been reduced. This citation has the potential to impact any residents in the facility who are on medications that are atypical to address behavioral issues. The following measures have been taken to assure ongoing compliance: • Residents on atypical medications to manage behaviors will have those medications reviewed in the facility review of behavioral medications at least every 6 months. Medications will be reduced as needed. • Social Services and Pharmacist have been educated regarding need to address and reduce these medications if residents are not exhibiting behavioral symptoms	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 54 attempted as appropriate. This was true for 1 of 5 sampled resident's (#11) who's documentation of targeted behaviors did not support the continued present dosage of the behavior control drug (Depakote). Findings include: Resident #11 was admitted on 7/3/02 with diagnoses that included dementia with behaviors, hypertension, hypothyroidism and depressive disorder. A physician's note, dated 9/25/05, stated "Pharmacy has recommended the decrease of her Depakote perhaps to 500 mg BID and if it is possible or feasible medication may be decreased to discontinuance." On 7/13/06, between 9:00 am and 10:30 am, the Social Worker validated that 9/26/05 was the last Depakote drug reduction for resident #11 (9 months ago). The resident was observed on 7/10, 7/11, 7/12/06 at 8:30 am in the hallway asleep and on 7/10, 7/11 and 7/12/06 at 11:45 am in the dining room asleep. The behavior flow sheet for 5/2 through 5/31/06 indicated no episodes of behavior for the targeted behavior "verbal aggression." Monitoring that behavior was discontinued 5/15/06. During the month of May 2006, three episodes of "physically resistive to cares" were documented. During the month of June 2006, verbal aggression was again identified as a targeted behavior with just one episode documented for the entire month. Four episodes of "physically resistive to cares" were documented.	F 329	MONITORING AND QUALITY ASSURANCE: • The Director of Nurses will monitor for compliance through routine review of residents on atypical medications for behavioral management. Identified areas of concern will be resolved immediately, and addressed as needed in the facility Performance Improvement meeting. Completion date: August 15, 2006	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 55 Assessment documentation was requested of the Social Worker and the MDS LN on 7/13/06 between 9:00 am and 10:30 am. No assessment information was provided indicating staff had considered the importance of the low number of behaviors and the setting of Depakote reduction goals. Despite the low number of target behaviors during the two month period, the facility did not have assessment information tied to the gradual dose reduction of the Depakote.	F 329	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and review of the facility's protocols for medication passes, the facility did not ensure medications were passed in a timely manner. The facility had a 11.3% error rate on medication passes. This deficient practice affected 1 of 13 sampled residents (#10), and 2 random residents (#16 and 17). The findings include: 1. On 7/10/06 at 2:15 pm, an LN administered the following medications: a. Resident #16 received Glucosamine 500 mg (milligrams), 1 tablet TID (three times a day). b. Resident #17 received Carbamazepine 100 mg, 1 tablet TID. OxyContin HCL (hydrochloride)	F 332	F 332 IDENTIFIED RESIDENTS: Resident #'s 10, 16 & 17 were reviewed by the ID team. There were no adverse effects noted. The eye drops were administered as indicated in the statement of deficiency. Medication times were adjusted as indicated. • The ID team will review other residents with orders for Ritalin to ensure appropriate dosing times. • In-service education will be provided to LN staff regarding medication pass times and timeliness in administration. MONITORING AND QUALITY ASSURANCE: The DNS and/or designee will observe medication pass weekly to observe for compliance. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 56 5 mg, 1 capsule QID (four times a day). Ritalin (methylphenidate) 10 mg, 1 tablet q (every) am and noon. According to the drug book information received by a LN at the facility, Ritalin's dosing for adults, if given for depression, is as follows: "...Give every morning before 9 AM, may be divided (e.g. 7 AM and 12 noon), but should not be given after noon..." Medications administered to random residents #16 and 17 were verified by the MD's Recapitulation Orders dated 7/06/06. According to the facility's protocol, the medication pass times were as follows: TID = 8am, 12 noon, and 4pm; QID = 8am, 12 noon, 4pm, and 8pm. On 7/13/06 at 1:45 pm, an interview was conducted with a LN. The surveyor discussed medication errors with the LN and asked for the facility's protocol on medication pass times. The LN stated, "I don't know where to find them, but I can ask another LN to get them." The protocol was received at 2:05 pm. 2. Resident #10 was admitted 10/4/04. A consultation report, dated 6/16/06, indicated the resident had slight progression of macular degeneration and dry eyes. The annual MDS assessment dated 6/20/06 indicated the resident had normal cognitition and decision making abilities. A physician's order included in the recapped orders, dated 6/6/06, indicated the resident was to receive Systane Artificial Tears four times daily	F 332	committee may adjust the frequency of monitoring as it deems appropriate. Date of Compliance: August 15, 2006	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 57 for dry eyes. On 7/10/06 at 10:00 am, the resident indicated she was supposed to receive eye drops 4 times daily, and even though she had asked the LN two times since the time the first dose was supposed to have been given (8:00 am), she had not yet received the eye drops. The resident expressed concern about her eyes, indicating she had recently been diagnosed with macular degeneration and she also had persistent dryness of her eyes. The surveyor informed the LN, on 7/10/06 at 10:15 am, about the resident's repeated requests for eye drops. The LN indicated he had been very busy and for that reason had not given the medication. The medication was administered on 7/10/06 at 10:30 am, at least 90 minutes late.	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on a complaint from the public, observation, resident interview, family and staff interview, and record review, it was determined that the facility failed to provide sufficient staff to provide care and meet resident needs in a timely manner. This was true for 14 of 15 sampled residents (#s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 and 15) and 2 random residents (#16 and 17) and had the potential to affect all residents in the facility. Findings include: 1. On 5/16/06 a complaint from the public was	F 353	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F 353 IDENTIFIED RESIDENTS: The ID team has reviewed resident #'s 1-13, 15, 16 & 17 related to having their needs met timely including ADL's and respecting dignity. Adjustments to the plan of care and staffing patterns were made as indicated. • Please refer to the plan of correction at F 154, F 241, F 312, F 318, F 332, F 309, F 313, F 314, F 315, F 324, F 328, & F 329 for specific information as to action taken to meet needs of the identified residents. MONITORING AND QUALITY ASSURANCE: • The DNS, ED and/or designee will monitor for compliance through the routine review of residents, facility rounds and general observations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 59 received regarding the lack of care and dignity issues related to resident needs. Refer to F241 as it relate to dignity issues and F312 as it relates to the facility's failure to ensure that residents received required assistance with oral care, nail care and bathing. 2. a. On 7/10/06 at 10:00 am, resident #10 indicated she wished she could be assisted to walk at least daily. She said she had fallen twice since admission. She said she usually took herself to the bathroom, but often felt unsteady when doing it. The care plan, with an update of 5/24/06, directed the resident was to receive daily strengthening exercises. Documentation on the RNA flow sheet did not indicate the services were provided between 7/1 and 7/12/6. On 7/13/06 at approximately 1:30 pm, an RNA was observed supervising resident #10 with ambulation in the hallway. When the surveyor asked why the RNA's had not done the strengthening exercises daily, the RNA indicated she had been pulled to do basic patient care because of the shortage of aides. b. A consultation report dated 6/16/06 indicated that resident #10 had slight progression on macular degeneration and dry eyes. The annual MDS assessment dated 6/20/06 indicated the resident had normal cognition and decision making abilities. On 7/10/06 at 10:00 am, the resident indicated she was supposed to receive eye drops 4 times daily. Even though she had asked the LN two times since the time the first dose was supposed to be given (8:00 am), she had not yet received the eye drops.	F 353	• Please refer to the plan of correction at F 154, F 241, F 312, F 318, F 332, F 309, F 313, F 314, F 315, F 324, F 328, & F 329 for specific information on monitoring and quality assurance to address the concerns noted. Date of Compliance: August 15, 2006	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 60 The surveyor informed the LN, on 7/10/06 at 10:15 am, about the resident's repeated requests for eye drops. The LN indicated he had been very busy and for that reason had not given the medication. The medication was administered on 7/10/06 at 10:30 am, at least 90 minutes late. Refer to F318 as it relates to the facility's failure to ensure residents received range of motion through the restorative nursing program on a consistent basis and F332 as it relates to the facility's failure to ensure that medications were given timely. 3. On 7/10/06 at 11:30 am, after observing care on hall #3, two aides responsible for 26 residents were interviewed. Aide #1 indicated she was regularly responsible for 13 residents on the day shift. Her resident's included resident #8 & #12 [refer to F312 for lack of nail care] and residents #10 and #12 [refer to F318 for lack of regular ROM exercises]. Aide #2 was interviewed in the presence of the LN consultant. Aide #2 indicated she was regularly responsible for 12 residents on the day shift. Her resident's included resident #11 (Refer to F318 for lack of daily ROM). 4. The most recent MDS assessments for resident #s 1-9, 11-13, 16 and 17 indicated the residents required 1 to 2 person extensive to total assistance with ADLs. 5. The facility did not provide sufficient staff to meet the following additional requirements related to Resident Rights, Quality of Life and Quality of	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 61 Care. Refer to: F154 as it relates to prompt facility response to residents' medical record requests. F309 as it relates to the facility's failure to provide proper equipment (ted hose) according to physician orders. F313 as it relates to the facility's failure to ensure that residents received vision and hearing assistive devices. F314 as it relates to the facility's failure to ensure preventative measures were consistently implemented to prevent the development of pressure ulcers, and the facility's failure to ensure that pressure areas were adequately assessed and consistently documented. F315 as it relates to the facility's failure to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. F324 as it relates to the facility's failure to ensure that each resident received adequate supervision and assistive devices to prevent injury. F328 as it relates to the facility's failure to ensure that residents received proper treatment and care related to respiratory and podiatry care. F329 as it relates to the facility's failure to ensure that residents receiving medications for behaviors were adequately assessed, reviewed, monitored and a gradual dose reduction attempted as	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 62 appropriate. This is a repeat deficiency from the 6/10/05 recertification survey.	F 353	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not ensure sanitary conditions were maintained in the following areas: 1) prevention of food contamination, 2) cleaning of equipment, 3) proper cleaning of the kitchen's physical facilities. This had the potential to affect 100 % of the residents who ate in the facility including 13 of 13 sampled residents (#1-13). Findings include: 1. Observations were made on 7/10/06 at 8:15 am with the FSS (Food Service Supervisor) and on 7/11/06 at 9:30 am with the FSS and the RD (Registered Dietitian). Food contamination potential: a) The following observations were made on 7/10/06 at 8:15 am and conditions remained the same when observed on 7/11/06 at 9:30 am . * A cardboard box labeled "cornstarch" was 1/2 full setting on an open shelf above a preparation table with the content exposed to dust. The box	F 371	F 371 IDENTIFIED RESIDENTS: • Resident #'s 1-13 were reviewed by the ID team and found to have no outcome related to kitchen sanitation issues. • The corn-starch was removed from the kitchen and discarded due to not being able to be sealed. • Lids of onion, paprika and cumin powders were closed and/or the items discarded. • The stainless steel wall behind the grill was cleaned. • The large mixer and blender were cleaned. • The large fan was cleaned. • The pot hand and arm protectors will be replaced as indicated. • The ventilation system located above the grill was cleaned. • The microwave ovens in the Teton and Therapeutic dining rooms were cleaned.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 63 top had been torn off making it impossible to reseal the content. * Lids were open on items including onion, paprika and cumin powders stored in individual tube shaped containers on an open shelf above a food preparation table. This could effect the quality of the powder and also had the potential to be contaminated with dust and debris. No comments were provided by the FSS or the RD regarding these problems. At 9:30 am, breakfast had been served and the clean up was in progress. Cleaning of equipment: b) Observations on 7/10/06 at 8:15 am included the following: * The stainless steel wall behind the grill was soiled with grease and dust. The FSS indicated the area was on a maintenance list for cleaning but he indicated he had new staff and they had not cleaned the area as needed. c) Observations on 7/11/06 between 9:00 and 9:45 am included the following: * A large mixer and the blender were not clean. They had dry batter in multiple areas on the frames and crevices of the frames. * A large fan was stored above the desert preparation counter. The fan was not clean and had dust and oil over the entire fan. The FSS indicated the fan was used to dry the floor after mopping. * Hot pot hand and arm protectors were very stained, worn (frayed) and soiled. Some of the food soil was of a sticky substance. The gloves were observed used to hold a pan of pasta with the soiled thumbs of the protectors inside the pan, creating a potential for cross contamination.	F 371	In-service education will be provided to the kitchen staff related to sanitation and cleaning procedures. Additionally, direct care staff will be provided in-service education on monitoring and cleaning procedures for microwaves. QUALITY ASSURANCE AND MONITORING: • The ED and/or designee will round in the kitchen and observe for compliance with kitchen sanitation including proper storage and equipment cleanliness. Additionally, microwave ovens will be monitored. • Any concerns will be addressed immediately and discussed with the facility PI committee as indicated. Date of Completion: August 15, 2006	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 64 On 7/12/06 at 10:00 am, the FSS [Food Service Supervisor] validated the need to maintain clean pot holders. Cleaning of the kitchens's physical facilities d) Observations on 7/10/06 at 8:15 am included the following: *The ventilation system located above the grill was in need of cleaning. Dust and oil globules were observed on the frame. The FSS did not know when the ventilation system had last been cleaned. He indicated maintenance took care of it. 2. During observations on 7/11/06 at 8:00 a.m. the microwave ovens in the Teton and Therapeutic dining rooms were noted to contain food spills and debris on the sides and bottom.	F 371	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F 387 IDENTIFIED RESIDENTS: The ID team has reviewed resident #'s 6 & 8 related timely physician visits. As noted in the statement of deficiency, resident # 6 was visited by the physician in the past 30 days and resident # 8 was visited by the physician within the last 60 days. • The ID team will review other residents to ensure a timely physician visit has been completed. Arrangements will be made as indicated to ensure a physician visit. • In-service education will be provided to LN staff and medical records staff regarding this requirement and the need to closely monitor. MONITORING AND QUALITY ASSURANCE: Medical records staff will maintain a log of physician visits to monitor timeliness. Any concerns will be reported to the DNS and/or designee. Arrangements will be made up to	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents were seen by a physician at least once every 30	F 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 387	Continued From page 65 days for the first 90 days after admission, and at least once every 60 days thereafter. This deficient practice affected 2 of 13 sampled residents reviewed for physicians' visits (#'s 6 and 8). The findings include: 1. Resident #6 was admitted to the facility on 7/29/99 with diagnoses of subdural hematoma, coma, quadriplegia and depression. Review of resident #6's record revealed the resident received a visit from the nurse practitioner on 12/3/05. The next documented visit was by the physician on 3/4/06, 3 months after the nurse practitioner's visit. On 6/26/06 the nurse practitioner visited the resident. This was 3 months and 22 days after the physician's visit. On 7/13/06 at 9:17 am, the DON was interviewed. The DON acknowledged the physician and nurse practitioner visits documented on 12/3/05 and 3/4/06 did not meet the 60 day requirement. The DON was able to provide documentation of the 6/26/06 visit later that morning. 2. Resident #8 was admitted 3/22/06. The attending physician failed to see the resident as required every 30 days for the first 90 days after admission. Documentation indicated the physician had visited only one time since the resident's admission, on 6/1/06. On 7/11/06, at 1:00 pm, the problem was identified to a LN in charge of the resident. She indicated the physician had been notified numerous times and was aware of being out of compliance.	F 387	and including medical director intervention to ensure timely visits. • The DNS will regularly review the physician visit log with medical records to ensure compliance. Any concerns will be addressed immediately and discussed with the PI committee including the medical director as indicated. Date of Compliance: August 15, 2006	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with facility staff, review of facility records, and review of resident records, it was determined the facility failed to provide an infection control program that would ensure that infections were investigated as to their potential cause, ensure that infections were controlled and prevented from spreading to other residents of the facility, and ensure that infections were tracked. This affected 8 of 13 residents (#2, 4, 5, 7, 8, 9, 11, 13) and 5 random residents (#14, 15, 16, 127, 18) and had the potential to affect 100% of residents of the facility. It was also determined the facility did not ensure 7 of 13 sample residents (#4, 5, 7, 8, 9, 11, and 13) had a influenza vaccine, PPD [tuberculosis testing] or pneumococcal vaccine to control the transmission of disease. Findings include: 1. Residents' physician orders, dated 6/06, included "May administer pneumovax injection" and "May have annual flu vaccine." The following residents, all of whom resided at the facility for longer than 90 days, had not received one or	F 441	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F 441 IDENTIFIED RESIDENTS: The ID team reviewed resident #'s 4, 5, 7, 8, 9, 11, & 13 related to immunizations and PPD's. The testing and/or immunizations were provided as indicated. When refused, documentation was provided in the record to indicate that risks and benefits had been explained. • The ID team will review other resident's immunization records to ensure timely immunization and testing and/or documentation of risks and benefits when refused. • In-service education will be provided to LN staff regarding timely PPD testing and immunizations including discussing risks and benefits as appropriate. Additionally, the ID team reviewed resident #'s 2, 4, 7, 8, & 13 related to infections. Adjustments to the plan of care were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 67 more of the diagnostic tests/vaccines necessary to control the transmission of disease, nor was there documentation indicating the residents were notified of the risks and benefits of the vaccines: Resident #4 - PPD and pneumovax Resident #5 - pneumovax Resident #7 - PPD and pneumovax Resident #8 - pneumovax Resident #9 - PPD and pneumovax Resident #11 - pneumovax Resident #13 - PPD, pneumovax and influenza On 7/12/06 at 10:00 am, the DON indicated the testing and/or immunization records for PPD's, pneumovax and influenza were not complete. She indicated residents whose PPD's were not known were being re-tested. 2. Record review indicated 5 sampled residents (#2, 4, 7, 8, 13) had a history of UTI's [urinary tract infections]. On 7/11/06, during an end of the day conference with the administrator, DON and nurse consultant, facility information that included names of residents who had infections, date of infections, causative agents, origin or site of infections and the documented analyzation of the information used to prevent further infections, was requested. On 7/12/06 at 10:00 am the DON indicated documentation on infection control compiled in April and May 2006 had not been maintained and could not be provided. She stated the administrator would provide infection control information that addressed infection data for the month of June. Facility documentation titled "Infection Monitor," dated 7/6/06, indicated the facility had 7 UTI's, 5	F 441	updated as indicated. Resident # 11 was reviewed and splint cleaned as needed. Finally, the PI committee will review relevant infection control data and ensure trends are properly addressed with education and monitoring. MONITORING AND QUALITY ASSURANCE: • The DNS and/or designee will review infection control data monthly to ensure trends are identified and acted upon appropriately. Additionally, medical records will audit records after admission to ensure timely completing of PPD and immunizations as indicated. Any concerns will be addressed by the DNS/designee immediately. • The PI committee will review relevant infection control data monthly to ensure appropriate action and monitoring is in place to prevent the spread of infections. Date of Compliance: August 15, 2006	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 68 URI's [upper respiratory infections], 3 skin and 3 other infections during the month of June 2006. The form indicated no trends identified and no action to address trends; inservicing to be done included, "handwashing, general infection control, VRE [vancomycin resistant]/standard precautions." No inservice documentation was provided indicating prevention efforts had been initiated through inservice training. If the inservice training had been done, there was no reassessment of staff's response to the inservice, for example, handwashing. Review of the facility's June 2006 infection control log indicated the facility had 9 UTI's that started in the facility in June and 4 that were ongoing that had started in the facility prior to June 2006 but still continued. This resulted in a total of 13 UTI infections in June with an approximate census of 60 to 70 residents. In locating the resident's with June UTI infections on the facility's floor plan, a trend was noted with the facility having 8 UTI's ongoing in June on the 200 hall. The room's included 204, 206 (2 residents), 208, 209, 210, 211 and 218. Identification of the trend of multiple residents residing in a specific area of the facility acquiring UTI infections may have resulted in the facility assessing staff's quality of handwashing, peri care and bathing to see if that was a causative factor. 3. Resident #11 was observed at noon on 7/10, 7/11 and 7/13/6 in the dining room wearing a fabric covered splint on her hand, wrist and lower	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 69 arm. The fabric was worn and covered with smeared food during all observations. 4. During observation on 7/12/06 from 8:00 - 8:20 a.m., soiled toilet paper and a used glove were noted on the floor at resident #1's bedside.	F 441	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observations, Resident Group interview and Centers for Disease Control (CDC) guidelines, it was determined the facility did not ensure handwashing was initiated by all staff when caring for residents to prevent the spread of infection. This affected 1 of 13 sampled residents (#8) observed during the provision of personal cares. Findings include: The CDC Guidelines for Handwashing and Hospital Environmental Control 1985, documented the following: "a. Handwashing is the single most important procedure for preventing nosocomial infections. b. The indications for handwashing probably depend on the type, intensity, duration, and sequence of activity. c...handwashing is indicated, even when gloves are used after situations during which microbial	F 444	F 444 IDENTIFIED RESIDENT: Resident # 8 was reviewed by the ID team related to infection control. No negative outcome noted. The staff member identified was verbally counseled regarding the observations. • The DNS and ED rounded in the center and made observations to ensure compliance with hand washing. In-service education will be provided to direct care staff related to hand washing and appropriate completing of ADL tasks. MONITORING AND QUALITY ASSURANCE: • Staff will receive in-service education during orientation upon hire and at least annually thereafter. Additionally, the PI committee may recommend additional training as it deems appropriate. • The DNS and/or designee will round routinely in the center and observe for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 444	Continued From page 70 contamination of the hands is likely to occur, especially those involving contact with...body fluids and after touching inanimate sources that are likely to be contaminated... d...handwashing should be encouraged when personnel are in doubt about the necessity for doing so." 1. On 7/10/06 at 10:35 am, an aide was observed doing incontinent care on resident #8. While wearing protective gloves, the aide proceeded to care for the resident who had a large amount of very soft, yellow/orange colored feces. The feces had oozed over the resident's abdomen, peri area and entire buttocks. About half way through the process, the aides gloves had feces visible on both the front and the back of the gloves. She removed the gloves and replaced them with another clean pair. She proceeded with the care, continuing to remove the feces. The feces was again visible on her gloves and before removing the gloves, the aide indicated she needed a brief. When walking from the resident's bedside to the closet, the aide proceeded to handle the resident's wheelchair and privacy curtain. She then handled the closet door knob. Before opening the closet door, she stopped and removed her gloves. Without washing her hands, she applied clean gloves, opened the closet door and obtained a clean brief. She then applied the brief, touching the residents clothing and skin in the process. With her gloves still on, the aide then was asked to obtain a paper cup by the RN who had come into the room to administer an oral supplement to the resident. With the same gloves on, the aide went out of the room, and returned with a paper cup for the RN. The aide then left the room with plastic bags containing soiled linen and soiled	F 444	compliance with hand washing. Any concerns will be addressed immediately and discussed with the PI committee as indicated. Date of Compliance: August 15, 2006	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 444	Continued From page 71 trash. She went to the dirty utility room, handled the door knob while going in, deposited the items and handled the door knob on the way out. She did not wash her hands and then preceded to enter another resident's room. At the doorway, a LN, in a non verbal reminding way, handed a container of hand sanitizer to the aide. 2. During group interview on 7/11/06 at 11:00 a.m., one resident stated and several others concurred, not enough handwashing was taking place on the part of staff during dining and personal care. This is a repeat deficiency from the 6/10/05 recertification survey.	F 444	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on review of the MARs (medication administration records) and staff interview it was	F 514	F 514 IDENTIFIED RESIDENT: The ID team reviewed the MAR for resident # 10 related to ability to read. The MAR was adjusted as indicated to ensure legibility. • The ID team reviewed other MAR's to ensure legibility. Corrections made as indicated. • The DNS reviewed with LN staff reviewing the MAR records monthly the need to ensure legibility. MONITORING AND QUALITY ASSURANCE: • A LN will review the MAR monthly to ensure accuracy and legibility. • The DNS will review MAR's with routine rounds to ensure completeness	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 72 determined the facility failed to ensure that each resident's MAR included a clearly legible print of the medications to be administered. This involved 1 of 13 sampled resident's (#10). Findings include Resident #10's MAR for the month of July 2006, included two medications that were not legibly printed and did not contain the name or the dosage of the drug. The drugs were signed as given July 1 through 9, 2006. The MAR only identified the date ordered and reason for the drugs. On 7/10/06 at 10:15 am the LN responsible for the resident's care indicated the mediation given for abdominal pain was Levsin 0.125MG PO TID (milligrams, per mouth, three times daily) and the mediation for "dry eyes" was Systane Artificial Tears 1 GTT OU QID (drops both eyes four times daily). The lack of ability to read the medication and directions had the potential to cause a medication error.	F 514	and legibility. Any concerns will be addressed immediately and discussed as indicated. Date of Compliance: August 15, 2006	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure and complaint investigation survey of your facility. The surveyors conducting the survey were: Kimberly Heuman, RN, Team Coordinator Lea Stoltz, QMRP Celeste Rush, RN Nicole Martin, RN Diane Green, RN Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the State Form exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. RECEIVED AUG 0 9 2006 FACILITY STANDARDS	
C 111	02.100,02,f f. The administrator shall be responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility, i.e., food services, housekeeping, maintenance, nursing, laundry, etc. This Rule is not met as evidenced by: Refer to F353 as it relates to the facility's failure to provide sufficient staffing to meet necessary care and services of residents.	C 111	Refer to the Plan of Correction at F 353	

Bureau of Facility Standards

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 119	02.100,03,c,iii iii. Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research; This Rule is not met as evidenced by: Refer to F154 as it relates to the facility's failure to ensure that residents received medication information requested in language that could be easily understood.	C 119	Refer to the Plan of Correction at F 154	
C 125	02.100,03,c,ix ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 as it related to resident dignity.	C 125	Refer to the Plan of Correction at F 241	
C 147	02.100,05,g g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by:	C 147	Refer to the Plan of Correction at F 329	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 147	Continued From page 2 Refer to F329 as it related to the use of unnecessary drugs.	C 147		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 as it related to food service sanitation.	C 325	Refer to the Plan of Correction at F 371	
C 644	02.150,01,a,i a. Methods of maintaining sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F444 as it related to handwashing.	C 644	Refer to the Plan of Correction at F 444	
C 669	02.150,03 PATIENT/RESIDENT PROTECTION 03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Refer to F441 as it related to infection control.	C 669	Refer to the Plan of Correction at F 441	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 733	Continued From page 3	C 733		
C 733	02.154,02,b b. Each skilled nursing patient shall be seen by the attending physician at least once every thirty (30) days for the first ninety (90) days following admission. Thereafter, an alternative schedule may be adopted for patient/ resident visits based on physician's determination of need, and so justified in the patient's/resident's medical record. At no time may visits exceed ninety (90) day intervals. All physicians' visits shall be recorded in the patient's/ resident's medical record, with a physician's progress note. This Rule is not met as evidenced by: Refer to F387 as it relates to the facility's failure to ensure residents were seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.	C 733	Refer to the Plan of Correction at F 387	
C 745	02.200,01,c c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Refer to F281 as it relates to the facility's failure to follow accepted standards of nursing practice during medication passes.	C 745	Refer to the Plan of Correction at F 281	
C 782	02.200,03,a,iv iv. Reviewed and revised as needed	C 782		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 782	Continued From page 4 to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to the facility's failure to ensure that care plans were revised to reflect residents needs.	C 782	Refer to the Plan of Correction at F 280	
C 784	02.200,03,b b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F309 as it relates to the facility's failure to ensure that residents were provided with proper equipment (ted hose) according to physician orders.	C 784	Refer to the Plan of Correction at F 309	
C 785	02.200,03,b,i i. Good grooming and cleanliness of body, skin, nails, hair, eyes, ears, and face, including the removal or shaving of hair in accordance with patient/resident wishes or as necessitated to prevent infection; This Rule is not met as evidenced by: Refer to F312 as it relates to the facility's failure to ensure residents who required assistance with oral care, nail care and bathing, received the necessary assistance. Also, refer to F328 as it relates to the facility's failure to ensure that residents received proper treatment and care related to respiratory care and podiatry care.	C 785	Refer to the Plan of Correction at F 328	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 789	02.200,03,b,v v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it relates to the facility's failure to ensure preventative measures were consistently implemented to prevent the development of pressure ulcers and that pressure areas were adequately assessed and consistently documented.	C 789	Refer to the Plan of Correction at F 314	
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F324 as it relates to the facility's failure to ensure that each resident received adequate supervision and assistance devices to prevent injury to feet.	C 790	Refer to the Plan of Correction at F 324	
C 795	02.200,03,b,xi xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Please refer to F315 as it is relates to ensuring a resident received the necessary care and treatment to maintain her highest possible bladder function.	C 795	Refer to the Plan of Correction at F 315	
C 796	02.200,03,b,xii	C 796		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 796	Continued From page 6 xii. Rehabilitative nursing current with acceptable professional practices to assist the patient/resident in promoting or maintaining his physical functioning. This Rule is not met as evidenced by: Refer to F318 as it related to promoting and maintaining physical function.	C 796	Refer to the Plan of Correction at F 318	
C 798	02.200,04,a MEDICATION ADMINISTRATION 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Refer to F332 as it relates to the facility's failure to ensure that resident medications were given timely.	C 798	Refer to the Plan of Correction at F 332	
C 879	02.203 PATIENT/RESIDENT RECORDS 203. PATIENT/RESIDENT RECORDS. The facility maintains medical records for all patients/residents in accordance with accepted professional standards and practices. This Rule is not met as evidenced by: Refer to F514 as it related to medical records.	C 879	Refer to the Plan of Correction at F 514	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

August 7, 2006

Nolan L. Hoffer, Administrator
Boise Health & Rehabilitation Center
1001 South Hilton Street
Boise, ID 83705

Provider #: 135077

Dear Mr. Hoffer:

On **July 14, 2006**, a Recertification and Complaint Investigation was conducted at Boise Health & Rehabilitation Center. Kimberly Heuman, R.N., Nicole Martin, R.N., Celeste Rush, R.N., Lea Stoltz, L.S.W., Q.M.R.P. and Diane Green, R.N. conducted the complaint investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001412

ALLEGATION #1:

The complainant stated the resident had a shirt on but pants and shoes had been removed. Only a thin blanket was covering the resident and the door was wide open leaving him in full view of anyone passing the room.

FINDINGS:

The resident identified by the complainant was no longer at the facility during the course of the investigation. Therefore, the resident could not be interviewed or observed. However, during the recertification survey of the facility, dignity issues were identified relating to privacy and personal hygiene of residents not being maintained by the direct care staff of the facility.

The facility was cited at F241 for failure to promote residents' dignity.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated the resident was agitated and the complainant discovered this was because he had soiled himself and had been soiled for close to three hours.

FINDINGS:

The resident identified by the complainant was no longer at the facility during the course of the investigation. Therefore, the resident could not be interviewed or observed. However, during the recertification survey of the facility, staffing, dignity and incontinence issues were identified. The investigations revealed privacy of residents not being maintained and staff not providing cares or meeting residents' needs in a timely manner by the direct care staff of the facility.

The facility was cited at F241 for failure to promote residents' dignity, F353 for insufficient staffing to provide resident cares and F315 for not providing appropriate incontinence cares.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated the resident could not call for help as his call button was clipped above his head and he was unable to reach it. (His range of motion would not allow him to reach that high.) The telephone was on a table that was also out of his reach.

FINDINGS:

The resident identified by the complainant was no longer at the facility during the course of the investigation. Therefore, the resident could not be interviewed or observed. During the survey, observations, resident and family interviews, and staff interviews, indicated there were no complaints regarding call lights or communication devices being placed out of reach of the residents.

In conclusion, it could not be substantiated that residents were unable to reach call lights or communication devices.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated there was a used adult diaper under the resident's bed and the closet designated for the resident's belongings contained someone else's underwear and socks.

FINDINGS:

The resident identified by the complainant was no longer at the facility during the course of the investigation. However, observations during the survey revealed environmental issues related to the complainant's observations.

The facility was cited at F444 for failure to maintain an environment free from potential infectious items.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #5:

The complainant stated the bathroom toilet adjacent to the resident's room was backed up and not repaired until 11:00 a.m. the next day.

FINDINGS:

Based on observations, review of maintenance records, resident interviews and residents' comments during the resident group meeting there were no findings that related to the complainant's allegation.

In conclusion, it could not be substantiated that a toilet was left in disrepair for an extended length of time on the dates specified in the complaint.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated they felt that staff gave feeble excuses for the resident's condition when they asked for the resident to be cleaned up and to have clean linen put on his bed.

FINDINGS:

The resident identified by the complainant was no longer at the facility during the course of the investigation. Therefore, the resident could not be interviewed or observed. However, during the recertification survey of the facility, staffing, dignity and incontinence issues were identified. The investigations revealed privacy of residents not being maintained and staff not providing cares or meeting residents' needs in a timely manner by the direct care staff of the facility.

The facility was cited at F241 for failure to promote residents' dignity, F353 for insufficient

staffing to provide resident cares and F315 for not providing appropriate incontinence cares.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #7:

The complainant stated the Certified Nursing Assistants (CNAs) were disrespectful and showed disregard for the resident's needs. The complainant stated the CNAs knew the condition of the resident. When they came to the room they stated knowledge of him coming in with a fracture and he had received a stool softener. One of the aides made the comment, "he wouldn't have to get out of bed but just whip it out and use the portable urinal."

FINDINGS:

The resident identified by the complainant was no longer at the facility during the course of the investigation. Therefore, the resident could not be interviewed or observed. However, during the recertification survey of the facility, dignity issues were identified relating to inappropriate staff to resident verbal communication.

The facility was cited at F241 for failure to promote residents' dignity.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Marcia Key

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj